CLINICAL MEMORANDA:

BEING

SELECTED CASES FROM THE WARDS

OF

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GLASGOW:

PRINTED BY ALEX. MACDOUGALL, 81 BUCHANAN STREET.

1893.

University of Glasgow

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PREFATORY NOTE.

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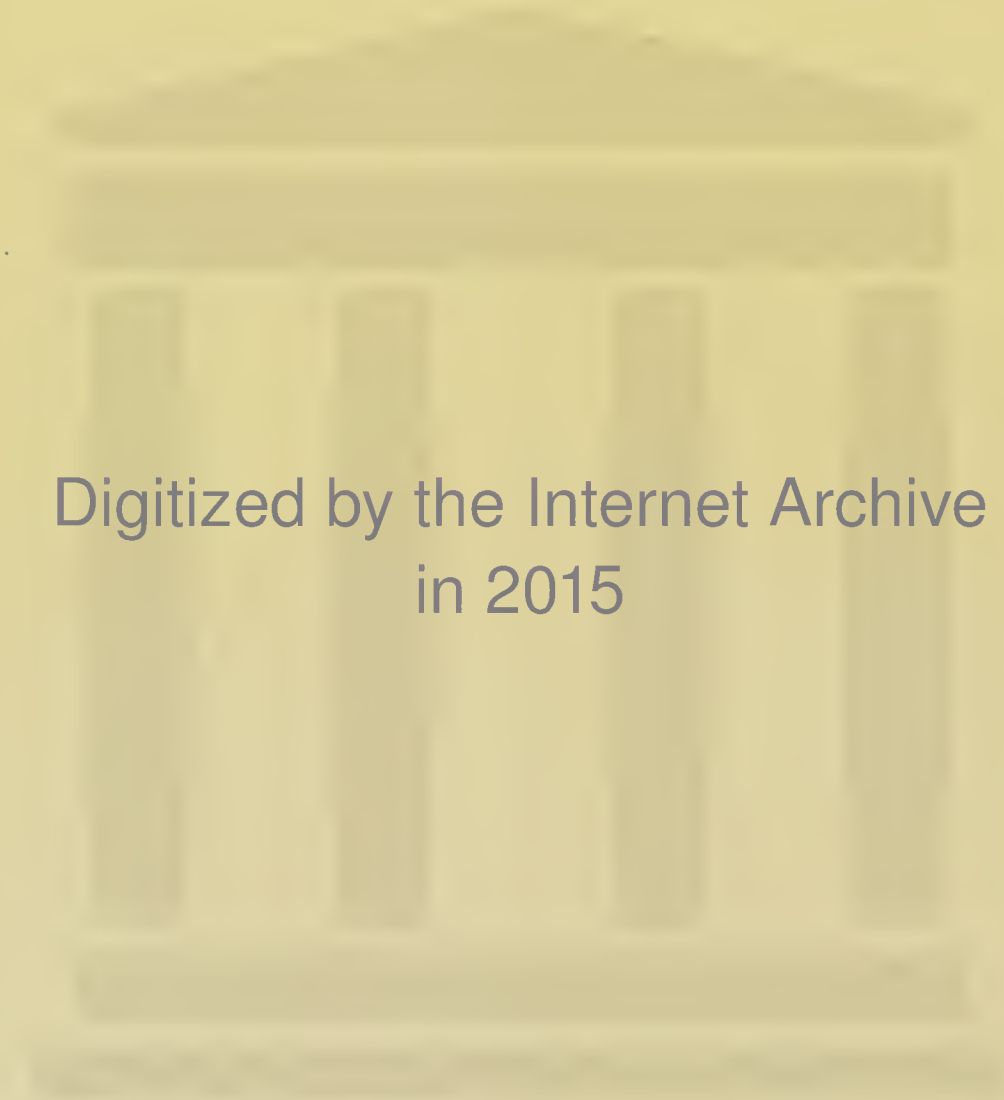
THE cases which follow have been selected from among those which have occurred in my wards in the Western Infirmary of Glasgow during the year 1893. It is proposed to continue the series from year to year, so that a mass of material may gradually be collected which, it is hoped, may prove of value to the student and to the practitioner.

My cordial thanks are due to Mr. William R. Jack, M.B., for the careful reports which he has taken of the cases.

T. M'CALL ANDERSON.

2 WOODSIDE TERRACE,
GLASGOW, *December*, *1893*.

CONTENTS.



CLINICAL MEMORANDA.

1. *Case of Pernicious Anæmia—Recovery Under Arsenic—Unusual Complication Terminating Fatally—Post-mortem Examination.*

A. M'D., æt. 17, was admitted to Ward VII, Western Infirmary, under the care of Professor M'Call Anderson, on 11th July, 1892.

Her family history is unimportant. The patient herself has always been very healthy until the commencement of the present illness. In the last two years she has grown very rapidly. The present illness began about eighteen months ago, when her relatives noticed that she was paler than usual, and she became languid, and lost strength. The pallor and weakness increased progressively. At first she had no other symptoms. Her appetite continued good, but after some time she felt an inordinate craving for oatmeal porridge and oatcakes, and she now has a similar craving for buttermilk. About eight months ago she became subject to attacks of faintness, which recurred about once a month. In November, 1891, owing to the steady progress of the disease, a doctor was called in, who prescribed Blaud's pills, and ordered a change to the country. Under this treatment she greatly improved, but became worse on her return home, and since then the symptoms have steadily progressed. She has not suffered from palpitation, nor does she complain of headache. Menstruation was regular until the beginning of June, but the period has not recurred since then. Her bowels were costive for a month before admission, but are now regular. During the last three weeks her appetite has been poor, but she has not lost flesh. For the last month she has

suffered much from thirst, and has passed a somewhat excessive quantity of urine. As a rule she sleeps well, although she is slightly feverish in the evening.

The patient is excessively pale as regards both the skin and mucous membrane, and the skin has a somewhat sallow tint. The blood corpuscles, counted on 13th July, numbered only 1,230,000 per cmm. A systolic murmur is audible over the whole of the cardiac area, but is best heard in the vessels of the neck, where a faint venous hum can also be heard. The pulse rate is 120. The temperatures since admission have been as follows:—

	Morning.	Evening.		Morning.	Evening.
July 11,	101·4	101·6	July 16,	100·0	100·6
,, 12,	102·2	...	,, 17,	98·8	100·6
,, 13,	100·4	100·2	,, 18,	99·2	99·4
,, 14,	99·4	100·0	,, 19,	99·4	99·2
,, 15,	99·4	100·4	,, 20,	99·2	...

On the 19th she passed 60 oz. of urine; on the 20th 64 oz. On the 22nd the urine was very pale, of specific gravity 1013, and highly acid. It was also slightly turbid, and there was a large deposit of crystals of uric acid. There was no albumen.

On 1st August Dr. Hinshelwood examined the eyes, and found multiple retinal hæmorrhages in both, but especially in the left. There was also optic neuritis on this side.

The examination of the other organs was negative.

The treatment, begun on 11th July, consisted of frequent light feeding by day and night, and the patient was warned not to lift her head from the pillow. The following mixture was given:—

℞.—Liq. arsenicalis, ... ℥ xc.
Fer. et ammon. citrat., . . . gr. xvi.
Tk. digitalis, ... ℥ xl.
Glycerini, ... ℥ i.
Aq., ... ad. ℥ viii. M.

Sig.—Half an ounce every three hours.

On the 13th arsenic was administered, in addition, by hypodermic injection of 5 minims of Fowler's solution every day, and on the 27th the dose was increased to 10 minims. Under this treatment the patient improved very much in every way. There was a marked gain in colour and strength, and, after about a month, she was allowed to sit up in the evening. Menstruation, however, remained absent.

On 3rd September the blood corpuscles numbered 2,666,000 per cmm., being a gain of 1,436,000.

On 9th October the temperature which, but for one or two transitory elevations, had been very nearly normal, ran up in the evening to 102·2°. She complained of chill, and said she had a sore throat, but there was no other symptom, except a pain at the seat of the hypodermic injections in the thigh. These were therefore discontinued, but one spot remained painful, tender, somewhat indurated, and reddened, until 12th October.

On the 11th a careful examination of the lungs was made, and it was discovered that the breath sound under the left clavicle was slightly interrupted during inspiration. There was no dulness in front, and behind the lungs were normal. From this time loss of flesh went on very rapidly, and complaint was made of slight dysphagia.

On the 12th October the evening temperature reached 103°, and was only slightly reduced by 10 grains of quinine, and two doses of 15 grains of antipyrine. The patient died on 19th October, between two and three A.M., the temperature having ranged for the ten days before death between 102° and 104°.

Post-mortem.—The following conditions were discovered:—There was great emaciation. The heart was normal in size, but pale, with diminution of the external fat. The left lung was adherent at the apex, and its upper lobe was considerably occupied by an almost homogeneous, nearly white, and somewhat tough infiltration, in the midst of which a small cretaceous mass was present. Microscopically, the apex presented a dense mycotic infiltration. The spleen was greatly enlarged, measuring $7\frac{1}{2} \times 4\frac{1}{2}$ inches. The kidneys were normal in size, and very pale. The stomach contained about 40 oz. of a deep green fluid, but there was nothing remarkable in the mucous membrane. The liver, which was normal in size, presented a slightly reddish colouration, and in it was found a single yellow tumour five-eighths of an inch in diameter, with distinctly demarcated boundaries. The œsophagus was coated with a yellow pale membrane, firmly adherent, and extending from near its upper to within an inch of its lower extremity. There was considerable enlargement of the glands around the cardiac orifice of the stomach, and towards the porta of the liver. Some of them showed rounded nodules in the cortical part. The liver did not present the accumulation of iron present in pernicious anæmia. The bone-marrow was not diffluent, but dark red.

Under the microscope there was still some fat in the large drops seen in adipose tissue. Otherwise the tissue was very cellular, the cells being small and not like the large granular cells seen in pernicious anæmia. The right lung was non-adherent. Its lower lobe was somewhat condensed. In the main branches of this lobe there was a pale fibrinous cast extending to the bronchi of a small diameter.

Remarks by Dr. Anderson.—There can be no doubt that this patient, at the time of her admission, was suffering from a typical attack of pernicious anæmia, and the absence of the usual *post-mortem* appearances is satisfactorily accounted for by the fact that she had practically recovered from that disease some weeks before she was cut off by the subsequent ailment; nor can there be any question that the disappearance of the symptoms was due to the arsenical treatment.

The illness which terminated fatally was only of ten days' duration, having commenced on the 9th and terminated on the 19th October. The *post-mortem* appearances were most unusual and puzzling, but that poisoning of the blood resulted from the entrance of micro-organisms into the system seems almost certain.

2. *Case of Cancer of the Lung, complicated with Secondary Cancer of the Liver.*

A. M'Q., æt. 65, a rivetter by trade, was admitted to Ward II of the Western Infirmary, under the care of Professor M'Call Anderson, on 9th November, 1892, complaining of swelling of the feet, legs, and abdomen, of two months' duration.

He states that his father died at the age of 100, his mother at 90. He is the youngest of a family of four brothers and three sisters. All the rest are abroad, and he has no information about them.

He has been exceptionally healthy, never having been a day ill until the commencement of his present complaint. About three months ago he suffered from a pain in the left loin, which he describes as a "soreness." He attributes this to exposure, which he has frequently undergone. Two or three weeks afterwards his feet began to swell. The swelling increased for some time, and then remained stationary. It is always worst at night after his day's work, and less in the mornings. There was no swelling of the face until within the last two or three days, when there has been a little in the morning. About two months ago the abdomen began to swell, the enlargement commencing upon the left side. It increased

in size, and a few days before admission he discovered that it felt like a hard lump. Within the same time it has been somewhat tender on pressure. For three weeks he has had shortness of breath, especially on going uphill. He states that he passed the usual quantity of urine before admission, but since then it has been scanty.

On physical examination, marked œdema of the lower extremities and swelling of the abdomen are found to be present. There is a great and irregular enlargement of the liver, the surface of which is nodulated and tender to pressure. The liver measures in the axillary line, 4½ in.; in the nipple line, 7½ in.; and in the middle line, 7¼ in. The vessels are atheromatous. A systolic murmur is present, loudest at the apex of the heart and in the aortic area, and the apex is displaced one inch to the left, and slightly downwards. On the right side of the chest, in front, there is marked dulness, extending to the lower edge of the fourth rib and 1½ inch beyond the middle line. Over this area there are feeble breathing and decreased vocal fremitus and resonance. Here, too, the systolic murmur is very distinctly heard. The veins in the neck and in both upper extremities are much distended. Examination of the urine gave the following results:—Quantity, 16 oz.; sp. gr., 1028; high colour; albumen absent; a few uric acid crystals. The temperatures are normal.

Dr. M'Call Anderson diagnosed the case as one of cancerous enlargement of the liver, and cancerous tumour of the right lung (leaving it undetermined which was the primary lesion), complicated with disease of the aortic valve, and perhaps also mitral incompetence.

The treatment consisted in frequent light feeding, regulation of the bowels, and stimulation.

The patient gradually grew weaker, and died on 26th November.

At the *post-mortem* the following conditions were discovered:—The heart was considerably enlarged, the enlargement affecting mainly the left ventricle. The aortic curtains were thickened, the left and anterior curtains being somewhat coalesced and infiltrated with lime. The water test revealed slight incompetence. The left lung was non-adherent, and showed hypostatic engorgement and œdema. The right lung was firmly adherent about its middle parts. At the lower parts of the upper lobe anteriorly there was a bulky condensation, consisting partly of a white tumour-tissue and partly of a grey condensation. The tumour-tissue bore a

special relation to the bronchi, surrounding and incorporating the stem passing to the area concerned, and also extending along some of the principal branches in this part. The spleen and kidneys were somewhat enlarged, but presented nothing remarkable. The liver was enormously enlarged, weighing 198 oz. It was the seat of great multitudes of tumours, varying in size from mere white little molecules to two inches in diameter. The tumours were very soft in consistence. There was no tumour in the intestine. Those in the liver and lung were of a cancerous nature. The lung tumour, on microscopic examination, was found to be a scirrhous cancer. Dr. Coats regarded it as the primary lesion.

3. *Syphilitic Affection of the Brain, &c.*

J. R., æt. 32, by trade a puddler, was admitted to the Western Infirmary, under the care of Professor M'Call Anderson, on the 2nd of February, 1892, with a history of "fits" of four months' duration.

The family history is unimportant. Four or five years ago he became subject to pain in the right hip, extending thence down the outer aspect of the thigh. He attributed it to exposure to extremes of temperature in the course of his work. It was medically treated, but without effect, and it gradually increased in severity. He has also suffered from an eruption known to puddlers as the "heat-rash," which he states is common among them. It consists of pimples occasionally appearing on the shins and shoulders.

With these exceptions he remained well till May, 1891, when he became affected with severe frontal headache. It occasionally ceased for a week or so, but always returned. About this time his friends noticed in him a strangeness of manner, and his memory became uncertain—*e. g.*, he once took the train to Ayr, and on his way forgot the name of his destination. The headache and "strangeness" became gradually more marked and more persistent. In the beginning of last October he was seized with a "fit" while walking in the street with his brother. Fourteen days afterwards he had a second seizure, while in his own house; and since then he has had several, varying in intensity and general character.

Shortly after the first seizure the sight of the left eye began to be dim, both for near and distant objects. When this commenced he "saw double" for a period of about ten days. The impairment of vision was accompanied by pain, and a feeling of heaviness in the eyeball. Two months afterwards his right eye became affected, and he states that he is now

quite unable to read. He also complains of the badness of his memory.

The fits, as described by his friends, are of three types:—

I. *Major Seizure*—

a. Aura; peculiar sensation from tips of left fingers up to left eye. Numbness all over, and "strange appearance." Duration about ten minutes, after which—

b. Cry, as if of agony.

c. Mouth drawn upwards and to left. Right eye turned towards nose; left eye closed.

d. Loss of consciousness, before which he prepares himself against falling by lying or sitting down, and during which the whole body is convulsed, and the tongue occasionally bitten. In this stage he foams at the mouth, and becomes very livid, the lips being almost black. Duration five to seven minutes.

e. Stertorous breathing, gradually becoming lighter. Lividity passes off, and face becomes clay-coloured.

f. Peaceful sleep, from which he awakes feeling better than he has been for the few days before the fit.

II. *Medium Seizure*—

a. Aura as in major.

b. No cry.

c. Facial condition as in major.

d. Convulsive movement of right arm, but no loss of consciousness.

e. Becomes very white.

f. Recovers immediately afterwards.

Total duration, ten to fifteen minutes, after which he remarks that he has been unwell.

III. *Minor Seizure*—

During conversation he stutters over a couple of words or so, then becomes intensely pale, and ceases to speak. There is no loss of consciousness, and neither tonic nor clonic spasms occur. The seizure lasts only a few minutes, and is followed by great exhaustion.

Of these types the third is the most frequent, and after it the first, which, however, is becoming more rare. The second occurs but seldom.

The patient confirms, in so far as he is conscious of them, this account of his seizures.

Before entering the Western Infirmary he was under the care of Dr. M'Vail in the Royal Infirmary, to which he was admitted 20th October, 1891. The house-physician, Mr. Tod, states that he then complained, as now, of headache. He had had

nine fits of an epileptic nature, and a tenth more cataleptic in character, a few days before admission. There was continuous and severe pain in the left frontal region, and occasional pain over the occiput. Both these points were tender to percussion, but not to pressure. He had constant tinnitus aurium, and complained of giddiness. On rising suddenly his sight became dim. The motions of the eyeballs were normal, and the pupils equal, reacting to light. The left eye was painful. Dr. Wolff examined the eyes on 23rd October, and reported a left optic neuritis with retinal hæmorrhage. There was no paralysis. On the night of 27th October the patient had two semi-aphasic attacks, the first lasting half an hour, the second not quite so long. In neither did he lose consciousness, nor were there any other symptoms. He left on 30th October, refusing to continue the treatment adopted. The headache was gone, but he was otherwise *in statu quo*.

Examined on admission to the Western Infirmary, the patient is observed to have a somewhat dreamy expression. His replies to questions are slow and delayed, and suggest a lack of intelligence. His eyelids droop so much as almost to amount to ptosis, and he seems to be somewhat deaf. Physical examination is negative, save that there is some tenderness to percussion in the left temporal region. His bearing is very slovenly.

Dr. Thomas Reid reports on the eyes:—"In both eyes there is well marked papillitis, with well developed 'choked disc.' The optic nerve is prominent to the extent of one millimetre in the left eye, less so in the right. A considerable exudation covers the retinal vessels at their point of emergence, so that they seem to spring from near the margin of the disc. In the right eye the congestive condition predominates; whereas, in the left, the exudation has a whitish character, suggestive of absorptive change. The inflammatory condition is of a subacute character, showing some slow progress in affection, and probably depends on tumour or meningeal affection. . . . Hypermetropia to 3 D exists in both eyes."

Dr. Barr's report on the ears is as follows:—"Hearing by air-conduction, right ear $\frac{24}{40}$, left ear $\frac{26}{40}$. Left ear much more defective for speech and the tuning-fork than the right. Bone conduction comparatively defective. Very marked tinnitus in left ear, having the characters of steam blowing off. On middle line of head, tuning-fork heard only in right ear. Appearances of membranes fairly normal. Believes lesion to be mainly in nerve structures."

The diagnosis of intracranial syphilis was made, for the following reasons:—

(1) The age of the patient, 32, a time of life when syphilitic affections of the nervous system are common.

(2) Fourteen years ago he contracted a sore on the penis while serving in Zululand with his regiment. It was, he states, of small size, and discharged somewhat, but was not very painful. It was followed, about a year afterwards, by buboes in the right and left groin. That in the right groin was opened by the army surgeon; the other was never opened.

(3) The pain in the hip was markedly worse at night. The frontal headache was also worse at night, and still is so.

(4) Under the treatment in the Royal Infirmary (Pil. hydrarg. and increasing doses of iodide) the headache disappeared.

On 3rd February, 1892, he was put upon 30 grains potass. brom. at night, and 10 grains potass. iodid. in the morning. On the 8th mercurial inunction was commenced. On the 11th the bromide and iodide were stopped, and as the headaches continued, 15 grains antipyrin was ordered when necessary. On 2nd March inunction was stopped, as it had caused a pustular eruption. The headache still persisted, but had considerably improved since admission. There was slight photophobia. No fits occurred during the patient's stay, although he twice had premonitions. He left on 5th March, 1892.

He afterwards attended the Eye Infirmary for six weeks, but without improvement. During this time he never had a typical seizure, but on several occasions had minor attacks, consisting of the aura—a sensation of numbness extending from the fingers and toes up to the eyes—and temporary loss of speech. Since he left the Infirmary he has been unable to work, and the pains in the head have become increasingly severe. The eyesight also continues to fail. At the beginning of May he had a major seizure, the only one of the kind since he was last in hospital.

He was readmitted on 17th May, 1892, since when the headache has been extending to the right side, and remains equally severe on the left. Sometimes, he says, he substitutes one word for another, and he has considerable difficulty in articulation. The substitution of wrong words is especially noticeable immediately after waking. He always knows perfectly what he wishes to say. The sight remains in much the same condition. Tinnitus is constantly present in the left ear. The frontal pain occasionally shoots through to the

occiput, but there is now no permanent occipital pain, though the hip pain, which is distinctly nocturnal in type, still persists to a less degree than formerly. He does not sleep well. He has had several minor seizures since admission.

On 10th June an aphasic attack took place, beginning at 8 A.M., and lasting till noon next day. Patient states that the fits are less numerous since mercury was commenced on 3rd June; but on the 9th there was one attack of numbness, beginning in the foot and fingers, and passing up to the eye on the right side. There was then no unconsciousness or aphasia. He is being treated by 30 grains of potass. brom. at night, and a daily hypodermic injection of one-eighth grain of hydrarg. perchlor.

Dr. Hinshelwood examined the eyes on 7th July, and reports that the discs are becoming much paler, especially the left. They have a filled-up appearance, and their edges are irregular and ill-defined. All the appearances are most marked in the left eye. Patient states that the headache and difficulty of speech are considerably diminished since readmission.

15th August.—Marked improvement in the headache and other symptoms, except the pain in the hip, which still persists. Yesterday a minor seizure occurred, lasting half an hour.

On the 14th and on the 20th August the patient had aphasic attacks, lasting an hour and twenty minutes respectively, with numbness passing from the toes and fingers up the right side of the face. The sight and the pain in the right hip are much as they were, but the headaches are very much improved, and also the general condition.

On 23rd August he weighed 10 st. $9\frac{3}{4}$ lb., as against 10 st. 7 lb. on 23rd May.

He left the Infirmary of his own accord on 3rd September, 1892.

Remarks by Dr. Anderson.—In this case the evidence of the syphilitic nature of the brain affection is not overwhelming, and the results of anti-syphilitic treatment were not brilliant. But, for all that, it is most probable that it had a syphilitic basis, while secondary non-syphilitic lesions may have resulted from the syphilitic affection, of the nature of inflammatory softening, &c., which, of course, could not be influenced by mercury or iodine. This result is far from uncommon, and hence the vital importance of making an accurate diagnosis, and of inaugurating treatment at the earliest possible moment.

4. *Copious Syphilitic Eruption, with Subsequent Head Symptoms.*

J. D., æt. 39, laundress, admitted to Ward VII of Western Infirmary, 30th April, 1892, in a torpid condition.

The patient's father died at the age of 64, her mother at 54, both of "paralysis." She is one of a family of seven. Of the other six one sister died at the age of 39 of "internal cancer." the remaining five are alive and well.

The history was obtained from a sister, who states that patient has all her life been very healthy, with the exception that seven years ago she had scarlet fever, for which she was eleven weeks in hospital.

About eleven weeks ago she complained of pain in her back and head, and a doctor was called in, who diagnosed influenza. From this she recovered in about a week.

Eight weeks ago the pain in her back and head returned, and rendered her unable to get about. Her sister does not know whether or not it was chiefly nocturnal. Three weeks afterwards a rash came out all over her body, and has persisted since then. A fortnight ago she fell into a state of stupor, in which she has continued since.

On examination, the patient is discovered to be in a condition of stupor, from which she can be roused when she is loudly spoken to. If told in a loud voice to put out her tongue she does so, and keeps it out until told to put it in again. There is no paralysis. The pupils are contracted, and there is a slight conjunctivitis in both eyes.

The whole body is covered with a copious dusky papular rash, most abundant upon the face, arms, and loins, where it is in some places almost confluent, less abundant upon the chest, abdomen, and extensor aspects of the thighs, and existing, although scantily, both upon the palms and the soles of the feet. The individual papules are mostly of large size, circular, dusky red, and occasionally distinctly coppery in colour. Many of them are surrounded at their bases by a collar of desquamation. They are flat-topped, only slightly raised, and unaccompanied by itching or irritation. Some are covered by small whitish scales, and into a few hæmorrhage has taken place. The eruption is manifestly syphilitic, resulting from recent infection.

On entrance patient's head was shaved, and an ice-bag applied; 5 grains of calomel were administered, and followed by a seidlitz powder. On the 1st of May frequent feeding was begun, and one-eighth of perchloride of mercury injected subcutaneously night and morning.

The stupor gradually deepened, and finally passed into coma. The patient died on the morning of the 5th of May.

On *post-mortem* examination a considerable subdural hæmorrhage was found, the blood covering in a thin layer nearly the whole of the convexity of the right hemisphere, and extending from near the base to very near the vertex. There was no other obvious lesion in the brain, nor in any of the other organs except the left lung, where a capillary bronchitis, accompanied by œdema, was found in the lower lobe.

5. *Hæmorrhage into the Spinal Meninges* (?).

W. R., aged 42, a builder, was admitted to Ward II on 21st January, 1893, complaining of loss of power in the arms and legs of a week's duration.

His father died at the age of 43 of "rheumatism," his mother of pleurisy. He has had seven children, of whom two died young; the others are alive and well.

He himself has always been a healthy man, with the exception that for the last four years he has had "rheumatism" of the shoulders.

A week before admission, while in his house and leaning against the dresser, he suddenly fell to the floor. There was no loss of consciousness, but both arms and legs were found to be completely paralysed. There was no ascertainable cause. Since then, his bowels have been obstinately constipated, and there has been dysuria.

Since the onset of his illness he has been recovering, and is now able to walk. As he does so, his legs are seen to be tremulous and weak, but there is no rigidity. Spasms are also absent. Both knee-jerks are exaggerated—the left somewhat more than the right. A slight ankle clonus is present upon the left side. On admission it was also present upon the right side, but cannot now be made out there. Both legs are easily held down against his efforts to raise them, but the left offers much less resistance than the right. The right arm can be moved with comparative freedom, the left but slightly. In the right hand the dynamometer registers 45, while in the left it is *nil*. The tendon reflexes are exaggerated in both arms, but more in the left than in the right. There is no anæsthesia, but he complains of numbness all over the body, especially in the legs and arms, and across the small of the back. Pressure upon the spine elicits tenderness extending from the sixth cervical to the second dorsal vertebra.

The patient was made to rest in bed, the bowels were regulated, and the state of the bladder carefully watched. A

fly-blister was applied over the tender portion of the spine. He was ordered 1 dr. of the liquid extract of ergot thrice daily, and at night-time a hypodermic injection of $\frac{1}{100}$ gr. atrop. sulph.

Under this treatment he rapidly improved, and on 15th February he walked much better and less tremulously. The dynamometer registered 42 in the left hand, in the right 122. The bowels were still very costive, but the dysuria had ceased to trouble him. The spine was no longer tender.

From this date the power of walking continued to improve, until there was no noticeable tremor, but he always complained of a slight stiffness, especially in the left leg. The grasp of the hands did not improve beyond the point above indicated.

General health was fairly good, but he said that he still felt rather weak, and the bowels, though less costive, still required aperients to move them. He left on 1st March.

Remarks by Dr. Anderson.—This is a very unusual case, not on account of the extent of the paralysis, but on account of the startling suddenness with which the symptoms made their appearance, altogether without premonition, and unaccompanied by sensorial disturbance. We were thus led to suspect that hæmorrhage—which, as a rule, occurs earlier in life within the spine than within the cranium—was the cause of the mischief, not into the substance of the cord, but within the meninges or outside the dura mater; for, in the latter case, while there may be sudden and complete paralysis of motion, sensation may be little, if at all, interfered with; and while, in hæmorrhage within the grey matter of the cord, the symptoms generally become more and more pronounced, and a fatal issue is the rule, in meningeal hæmorrhage a more or less complete recovery, as in our patient, may reasonably be anticipated.

Whether there was any antecedent organic lesion of the cord—tumour, or the like—it is impossible to say, although it is worthy of note that, on admission, there was tenderness over the lower cervical and upper dorsal spines; while, for several years, the patient had complained of pain referred to the shoulders.

6. *Left Hemiplegia complicating Tumour at the Root of the Lung.*

T. L., æt. 48, ironplaner, was admitted to Ward II of the Western Infirmary, under the care of Professor M'Call Anderson, on 8th November, 1892, with loss of power in the left arm and leg of eight days' duration.

The family history reveals nothing bearing on the case. From 1866 to 1878 he served in the army, and had occasional attacks of malarial and other fevers at foreign stations, but otherwise he enjoyed good health. After his discharge he remained well until two months ago, when he had an attack of "inflammation of the lungs," which kept him in bed for seven weeks. Eight days before admission, during convalescence, as he was walking along the street he felt his left leg become heavy, so that he could only lift it with difficulty. He describes it as "trailing." Next day his left arm also became weak, and within four days paralysis was complete in both limbs.

On examination, anæsthesia was found to be present in the paralysed limbs, affecting particularly their distal parts, and being more pronounced in the leg than in the arm. There was no rigidity or wasting, and no exaggeration of the reflexes. A basic systolic murmur was present.

A cortical lesion of the brain, involving the centres for the arm and leg, but not the face, was diagnosed, and as the urine was albuminous, it was considered probable that the lesion was hæmorrhagic, and the more so as the paralysis was left sided, thus rendering embolism less probable.

The fatal attack occurred on the evening after admission. Up till then the patient had remained in much the same condition. At 8·15 he attempted to rise in order to make water, but in the attempt he suddenly fell back upon the pillow. His face became flushed, and his breathing stertorous. Consciousness was lost at once, and in a few minutes he was dead.

At the *post-mortem* the right hemisphere was found to be bulkier than the left.

The vessels at the base of the brain were slightly atheromatous. On cutting into the right hemisphere, a large cavity occupied by altered blood was exposed. It was situated in the corona radiata, and undermined the upper part of the ascending parietal convolution, the upper and anterior parts of the parietal lobe, and the corresponding portion of the convolutions on the median surface. There was no blood in the lateral ventricles, but they contained an orange-coloured fluid.

The left ventricle of the heart was found to be enlarged. The aortic valve was competent, but the arch of the aorta was very atheromatous and dilated.

The right lung was somewhat firmly adherent and highly œdematous. The left lung was still more firmly adherent. At its root a bulky tumour was found, extending into the

substance of the lung. It centred around the main bronchus and its branches, the walls of the latter being incorporated with its substance, and it reached the surface along the interlobular connective tissue, but did not extend under the pleura. Its tissue was of a dead white appearance, and moderately consistent. It presented over a considerable surface inside the pericardium, but did not extend to the visceral layer. On microscopic examination in the fresh state, the tumour was found to consist of a great quantity of cells, usually small, with round or oval nuclei. There was a very sparse fibrous intercellular substance, and nothing like a cancerous stroma. The tumour, therefore, was a round-celled sarcoma.

7. *Case of Anæmia (?) with well marked Dropsy of the Face and Lower Extremities.*

A. G., æt. 21, telephone operator, was admitted to Ward VII on 9th January, 1893, complaining of swelling of the feet and legs of three months' duration.

Both her parents are dead—the father at 56, of "stoppage of the bowels," the mother at 48, of a "tumour of the liver." Of their seven children, six survive. One died at 13, of inflammation of the bowels; the rest are alive, and, except the patient, well.

Her own health has in the past been good. Three years ago an accident to her right knee kept her in the Kilmarnock Infirmary for six weeks. During part of this time both her legs were swollen, but this passed off a fortnight before she left. It returned soon afterwards, and she went to the Glasgow Royal Infirmary for advice. There she was told that both her legs and knee were quite well, and shortly afterwards the swelling disappeared. She remained in good health till the onset of her present illness.

Four months ago, probably as the result of a wetting, her ankles, and soon afterwards her legs, again began to swell. Except for this she felt perfectly well. She had had no previous feverishness, rigor, or any other symptom, except slight pain in the back. The swelling was at first very considerable. Within three weeks of its appearance she noticed that her eyes and face were swelled on rising in the morning. This disappeared as the day advanced, while the legs became more swollen. These symptoms have persisted until now, and are all that she complains of. She has never noticed any change either in the quantity or the colour of her urine, nor has she had any headache. Her sight is perfect. The appetite is good, and the bowels were always regular until

she took to bed, since when they have been somewhat costive. She has no cough, dyspnœa, or palpitation. She menstruates regularly.

On examination she is noticed to be pallid. This, she says, appeared at the beginning of her illness. The second aortic sound is slightly accentuated, but there is no increase of cardiac dulness, nor any murmur. The pulse gives to the finger the characters of slightly increased tension, but this does not appear in the sphygmogram. The other organs are healthy. There is considerable œdema of the feet, legs, and face. The urine is faintly acid, of specific gravity 1021. It contains neither albumen nor sugar. Abundant epithelial cells are present. The quantity varies between 30 and 40 ounces.

On 23rd January, after being under observation for some days, during which albumen was never found, the patient was put upon milk diet, six pints of skimmed milk daily, and potus imperialis. She was kept in bed. On 26th January light food was substituted for the milk diet, and on 1st February the skimmed milk and potus imperialis were replaced by an occasional injection of pilocarpine at night, and Blaud's pills with arsenic in the bipalatinoid form. Under this treatment she improved very rapidly, and left on 10th February. Albumen was never found in the urine, nor were casts ever observed, though frequently looked for. The anæmia had almost disappeared; on 7th February the blood corpuscles numbered 4,140,000 per ccm. When she lay still in bed there was no œdema, but on rising, the ankles became slightly swollen. From 1st February the quantity of urine had risen to 50 ounces.

Remarks by Dr. Anderson.—The symptoms present in this case were very unusual. The well marked dropsy of the lower extremities and face, and the pallor, led to the provisional diagnosis of tubular nephritis, a suspicion which was, however, negatived by the total absence of albumen and casts in the urine, as well as by the futility of treatment directed against that condition. Those who hold that tubular nephritis may exist without albuminuria might point to this as a case in point, but he does not believe in the existence of such a condition. Indeed, there can be no doubt that, prior to the differentiation of myxœdema, most cases of that disease were held to be illustrations of tubular nephritis, without albuminuria. On carefully weighing all the symptoms, he thought that the balance of evidence was in favour of this being an illustration of anæmia, and all the more as rapid improvement

took place under the influence of arsenic and iron. At the same time it must be admitted that marked œdema of the face is not a common occurrence in cases of anæmia.

8. *Case of Ephidrosis Cruenta.*

B. S., a girl of 12 years of age, was admitted to Ward IV on 17th January, 1893, her illness being of eighteen months' duration.

The family history is unimportant. Her general health has always been good but for occasional headaches. No cause can be assigned for the outbreak which, when it first appeared, attacked the lip and brow, and afterwards involved the face, arms, body, and legs in succession. It affects only a limited area at one time, and leaves one part to reappear in another. Varying intervals elapse between successive crops, sometimes one or two days, sometimes as much as a fortnight; but the old patches have never been entirely healed before new ones came out. During the month before admission she had two or three bleedings from the right ear and from the nose, by which she lost a good deal of blood. These attacks lasted about a quarter of an hour. She has never menstruated. The urine and temperature are normal.

Shortly before the appearance of each crop of eruption, the patient feels rather sick. Then a red and circumscribed erythematous patch, of varying diameter, but usually round, comes out, oftenest upon the face or the arms, but not infreqently upon other parts of the body. After an interval of from a few minutes to half an hour the central portion of this patch becomes more intensely red, and forms an oblong or more rounded figure, from half an inch to an inch in length, and a quarter of an inch broad. Over this area the corium appears to undergo rapid solution, and a watery serum exudes, which occasionally is distinctly blood-stained. At or near the margin, either slightly before or simultaneously with the development of the central spot, a ring of deeper colour forms, but does not go on to exudation. This ring is about half a finger's breadth in width. Each patch of eruption remains out from half an hour to an hour and a half, and then gradually fades. The serous or sanguineous exudation dries up, and forms a palish or a dark-brown scab, according as blood was absent or present. In a week or so this scab falls off, leaving behind a pink cicatricial tissue, which is for some time tender to pressure.

Each crop of eruption is usually composed of several patches, which appear at irregular intervals. Sometimes two

or more come out together, sometimes they follow each other at intervals of about half an hour, or a longer time may intervene. The whole crop has usually appeared within a few hours. The separate patches appear very rapidly. The eruption is never itchy, and only occasionally painful. Where the exudation is only serous, it bleeds very readily if touched.

On admission, patches of the cicatricial tissue referred to were found on the forehead and legs; and within a few days others appeared on the cheeks and on the dorsum of the right arm and hand, where their long diameter corresponded to the length of the limb.

The treatment consisted in hot hip baths with mustard, and the administration of pil. aloes et ferri. Towards the end of February Carlsbad salts were added. The patient, however, improved but slightly, fresh crops of eruption appearing every few days. Her general health remained excellent.

Note.—Since the date of the above report, the treatment has been changed. The patient was put upon ergot of rye. The attacks of eruption then rapidly diminished in number, and she was taken away by her mother upon 11th April, 1893. At that time she had had but one attack in five weeks, a fortnight before she left. An eruption of eczema appeared upon the back of the head about a week before she left the Infirmary. Otherwise her general health was in every way good.

Remarks by Dr. Anderson.—There can be very little doubt that this is a case of vicarious menstruation, and that no permanent improvement is likely to occur until menstruation is fully established. A very similar case was recorded a good many years ago * in which the symptoms rapidly disappeared when menstruation became more regular, and there is good reason to hope that a similar result will follow in the present case.

9. *Rheumatism with Cerebro-Spinal Symptoms.*

T. G., æt. 32, a van driver, was admitted to Ward II on 21st April, 1893, complaining of pain and stiffness in the back of the neck, and of pain in the lower part of the abdomen.

On 9th April, a cold and windy day, he was driving his van all day. He felt in his usual health that night, but next morning he woke with a severe headache, and had a shivering fit which lasted all day. At the same time he had sharp pains in the joints of his legs. He lost his appetite entirely, and took to bed. There was no vomiting or nausea. His

* *Lectures on Clinical Medicine*, by T. M'Call Anderson, M.D. (Macmillan & Co., London), p. 228.

bowels were at first costive, but have become somewhat loose since 16th April, when he took a dose of medicine. The joints have not swollen at any time, but have been very painful on movement, and the pain has gradually travelled from the legs up the body. He has perspired freely during the illness, but the odour of the perspiration presented no marked peculiarity.

On 14th April he was wakened in the early morning by very severe pain in the frontal and occipital regions, which made him dazed and stupid, and caused temporary impairment of vision. Later in the day he had several attacks of vomiting preceded by sickness. He does not recollect the details of this part of his illness, but was afterwards told by his wife that he had been delirious. Since the 14th he has constantly suffered from stiffness of the back of the neck, preventing motion of the head to either side. Any attempt at rotation caused a pain which shot up the sterno-mastoids, and was worst behind the ears. He also felt pain along the costo-vertebral joints, though not directly over the spinous processes, but he has had no palpitation, dyspnœa, or pain on the left side of the chest. There is no cough.

When a lad, after exposure on his van, he had a "fever" which lasted three weeks. Beyond that his feet and legs swelled, he remembers nothing of the illness, and from that time till now his health has been good.

There is no history of rheumatism in the family.

On admission he had a dazed appearance, and his eyes were dull and lustreless. There was tenderness of the muscles at the back of the neck, and also of the costo-vertebral joints, but none over the spinous processes. He perspired freely, and seemed very weak. The pulse was 88, regular and soft. The right border of cardiac dulness was at the left margin of the sternum, the upper border at the lower margin of the third rib, and the left in the nipple line. There was no murmur, but the first sound was slightly muffled. The lungs and liver were healthy.

23rd April.—Patient has had attacks of violent delirium throughout the day, attempting to get out of bed, &c. His pupils are rather sluggish in response to light, the right being rather more dilated than the left. The temperature has been generally above 100°, the highest being 101·4° at 4 P.M. yesterday. Pulse remains regular (88). He never asks for food, but does not refuse fluids. The evacuations are not passed in bed.

25th April.—Temperature still slightly over 100°. He lies on his side, sunk in the bed, with his knees a little drawn up. He recognises nobody, and is quite delirious. The pupils are

very sluggish, but even. He has a slight cough, which gives him frontal pain. Pressure on the back of the neck elicits merely a slight wrinkling of the forehead. The pulse is still regular.

He continued drowsy and delirious with slightly elevated temperature till the 29th, when the temperature fell to normal, and he became more rational, although he still wandered at intervals. On the morning of that day, and on the day before, he had been very sick. The pulse was regular throughout.

From this point he improved in every way. Delirium disappeared, the headache and costo-vertebral tenderness had gone, and also the pains in the joints. He was moved from the side-room into the ward on 5th May. This was followed by a relapse, the temperature rising again to 102·2°; but on the 7th it fell once more to normal, and has remained so since. On 10th May he was practically convalescent, and complained of nothing but weakness. The right pupil, however, was still slightly larger than the left.

Remarks by Dr. Anderson.—The symptoms in this case were so alarming when the patient was at his worst that few who saw him had much hope of his recovery. The fact, however, that the illness apparently resulted from a chill, and set in with pains in the joints accompanied by profuse perspiration, led to the hope that the cerebro-spinal affection was of a rheumatic character. Accordingly, on 21st April, he was put upon salicine, 10 grains every hour, increased on the 23rd to 20 grains, along with milk diet, and with the very satisfactory result above mentioned, thus fully verifying the opinion which had been given.

10. *Shell of Hazel-nut in Right Bronchus.*

C. M'D., æt. 16, a domestic servant, was admitted to Ward VII on 16th March, 1893, complaining of cough, wheezing, and shortness of breath of five months' duration.

The family history is unimportant, and the patient has been quite healthy but for frequent headaches. She is not usually costive.

Five months ago she was cracking a nut in her mouth, when the shell broke into several pieces. At the moment she happened to laugh, and accidentally "swallowed" the nut. As it passed over she felt a "jag" in the throat at the level of the larynx, and had a sensation of choking, accompanied by violent coughing. The pain and dyspnœa, which were very alarming, lasted for ten minutes, and then passed off. She went at once to a doctor, who made her drink some water, and said she had probably merely swallowed the nut, but

in doing so had hurt her windpipe. Very shortly after the accident her respiration became noisy and wheezing, and this symptom has never disappeared. It was worse during the succeeding night and day than it has been since, and from that time it has never varied in intensity. A fortnight afterwards she became feverish, and for two days suffered from headache. She took to her bed, to which she was confined for eight weeks. A week after the fever she developed a cough, and a feeling of soreness set in at the base of the right lung, three inches below the angle of the scapula. It was aggravated by drawing a deep breath, or by coughing. It lasted for a month, and then disappeared. The cough persisted for a month longer, and was accompanied by expectoration, at first white, frothy, and slightly streaked with blood; afterwards yellow, and free of blood. At this time she was said to have congestion of the right lung. While in bed she perspired much, but not more at night than in the day. This ceased when she began to go about. From Christmas, 1892, until seven weeks before admission she was not confined to bed, and had no other symptom than the wheezing. About the end of January she again saw a doctor, and was ordered back to bed. She was told she had inflammation of the windpipe, and fly-blisters were applied. Since then she has kept her bed. Her voice has never been affected during her illness.

While lying she has lost flesh and colour. She has also had frequent bleedings from the nose, and occasionally from the ears. These occurred at irregular intervals. The attack sometimes lasted for a week, and was often repeated at night and in the morning for several days. She has only menstruated twice, once in December and once a fortnight before admission. On the latter occasion she caught cold, became feverish, and suffered from headache. Her cough also got worse. Since admission she has noticed a diminution in the quantity of her urine.

On the day of admission Dr. Walker Downie examined her larynx, and found it normal.

On examination the patient appears somewhat pale. The wheezing respiration is distinctly audible on standing beside the bed. Dulness is present at the right base behind, extending upwards to within a short distance of the angle of the scapula. Musical and wheezing râles are audible all over the right side of the chest, especially behind and towards the base. Respiration is weaker all over the right side of the back than on the left, and the vocal resonance and fremitus

are diminished in the dull area. The expectoration is free from blood.

The heart and other organs are healthy.

The patient remained in much the same condition until 28th March, when, after a little coughing and expectoration of blood-stained sputa, she coughed up two small pieces of nut about one-eighth of an inch square. There was a slight soreness in the throat before they were brought up. There was no further change until 3rd April, when she expectorated another piece of nut-shell, equal in size to about two-thirds of the shell. No blood was expectorated with it, but its passage hurt the throat considerably. The wheezing stopped immediately after the shell had been got rid of, and thereafter all her symptoms rapidly disappeared. Within a few days the cough had completely ceased, and shortly afterwards the basal dulness cleared up entirely. She felt in every way quite well, and was dismissed on 3rd May, 1893.

11. *Hydronephrosis.*

A. G., aged 30, a weigher by trade, was transferred from Dr. Buchanan's to Dr. Anderson's wards on 4th February, 1893. He complained of pain and swelling in the right side, under the lower ribs, of about three weeks' duration.

The family history is unimportant.

But for an attack of measles fifteen years ago, patient has never been confined to bed. His health has always been excellent but for an occasional and slight dyspepsia.

Three weeks before admission he made a false step while coming down a stair, and, to prevent falling, twisted his body violently, so that he "strained himself." The next time he passed water it had a dark red colour. He does not remember whether or not he had emptied his bladder before the accident. The redness of the urine continued for about a week. At first there was no pain, but in a couple of days it set in on the right side, just under the lowest ribs. It was at first sharp, but became, after a little, dull and heavy. Since then it has been almost constantly present, but is not now nearly so severe as at first. About the same time a swelling began to appear in the same situation, which gradually increased in size for some time—he is not sure how long—but latterly it has remained stationary. A doctor examined his urine, and told him that the colour was due to blood. The blood was intimately mixed with the urine during micturition.

On examination, a soft elastic swelling is discovered lying under the right lower ribs. It is slightly tender to pressure,

extends from the fourth rib to 3 inches below the costal arch, and round the right side to the back, filling up the lumbar region behind. It is quite dull to percussion. In front the dulness is continuous with that of the liver, and behind it occupies the right lumbar region, extending upwards to the base of the lung, to within a short distance of the angle of the scapula. In front a portion of the tumour, lying about 2 inches under the costal arch and slightly to the left of the nipple line, is more prominent than the rest, and is semi-fluctuant. There is no clear percussion in the situation of the ascending colon.

The other organs are healthy.

The urine has a sp. gr. of 1015, and contains abundant urates, but no albumen or blood.

The temperature from 4th February to 11th February varied in the morning between 98·6° and 101°, and in the evening between 100·4° and 102·8°. The patient is somewhat thin, and perspires a good deal.

On 12th February blood appeared in the urine for the first time since admission. The urine was very dark, acid, of sp. gr. 1020, and contained albumen and a copious bloody sediment. Dr. Anderson drew off a small quantity of fluid from the prominent portion of the swelling, which, with the urine, was sent to Dr. Coats for examination. His report was as follows:—"The fluid removed by puncture and the urine have somewhat similar characters. In both there are many red corpuscles, mostly shrunken, and probably old, and in both there are many leucocytes, mostly fatty and old. The pus corpuscles are most abundant in the urine, and the blood in fluid. The two have probably the same source." During the afternoon of the 12th the temperature rose to 104·2°, fell at 8 P.M. to 102·6°, but rose again at 4 A.M. on the 13th to 104°. At this level it remained, in spite of two doses of 10 grs. of quinine, till midnight, when it fell to 101·8°, and next day (the 14th) varied between 99·4° and 101°. Blood remained abundant in the urine till the morning of the 14th, when but a small quantity was present. Later in the day, however, it was more copiously passed, but on the 15th it disappeared entirely. Owing to the puncture, the anterior prominence disappeared. The tumour also contracted somewhat, and on the 17th measured, in the nipple line, 7½ inches. The temperature varied between 98·4° and 101°, showing a distinct evening rise; but the patient expressed himself as very comfortable.

From this time there was little change in his condition.

The evening rise of temperature became somewhat less marked and intermittent. Blood did not reappear in the urine, the quantity of which varied, as a rule, between 40 and 60 oz. On 1st March 70 oz. were passed, and on three occasions thereafter 76 oz. The sp. gr. varied somewhat; on 20th February it was as low as 1010, and on 23rd March reached 1022. Albumen was absent, except for a trace which was noted on 1st March.

The tumour did not contract any further. The patient left of his own accord on 24th March, 1893, Professor George Buchanan being of opinion that, on the whole, operative interference should be avoided.

12. *Malignant Tumour at the Base of the Brain, with Secondary Nodules in the Liver.*

W. S., aged 46, by trade a ferryman, was admitted to Ward II on 23rd January, 1893, complaining of headache of eight, and loss of sensation on the right side of the face of six months' duration.

His father died, at the age of 50, of cancer of the stomach, his mother, at 46, of some form of heart disease. They had a family of three—two brothers and a sister. The brother died in childhood; the sister is alive and well. The patient is married, and has had eight children. Of these, one died before the age of three months, about six years ago; one was still-born, between three and four years ago; and a third died, like the first, before the age of three months, about three years ago.

His past health has been excellent. Until six years ago he was employed as a dock labourer, and, though much exposed, he never had more than an occasional cold. He then became a ferryman, and for some time drank considerably, but he has latterly been less intemperate.

In May, 1892, he began to complain of pain in the right ear, unaccompanied by any discharge. For this he was treated for a time, but without effect, and in the course of a month or six weeks he became completely deaf on that side. About the same time he suffered much from headache. The pain was very severe, and made him feel as if the head would burst. It was almost continuous, but much aggravated at night. At first it was confined almost entirely to the right frontal region. Since its onset the pain has hardly ever been completely absent. Of late it has extended to the left frontal region, where, however, it is less severe; and it still preserves the nocturnal character.

In June, 1892, a fulness appeared on the right side of the neck, between the angle of the jaw and the ear. Its size was variable, the swelling being now very marked, and now almost absent. It never caused any pain. Blisters, which were several times applied, reduced it only temporarily. A similar swelling, above the outer part of the right clavicle, has existed, he states, for many years. A month or so after the appearance of the fulness described, the patient began to notice a loss of sensation in the right side of the face, which was accompanied by loss of power in the muscles. The two symptoms very gradually grew worse, and it was not till three or four months later that anæsthesia and paralysis were complete. In September, 1892, the right eye became affected. It was turned inwards towards the opposite side, and about the same time his sight became a little dim.

His general health remains good, although there is slight constipation.

On examination, the whole of the right side of the face is found to be paralysed. He cannot wrinkle his forehead, nor draw up the angle of his mouth, which is pulled towards the left when he attempts to do so. Food lodges between the right cheek and the gums. Anæsthesia extends over the whole of this side of the face to the middle line. It involves the ear, and is continued on to the head for about 3 inches beyond the margin of the hair. The right side of the nose and the neighbouring part of the cheek are much swelled and inflamed, and the right nostril is the seat of a discharge which forms dark-brown crusts about the orifice. There is complete ptosis on the right side, and internal strabismus. The eye cannot be rotated outwards, and its upward movement is slightly impaired, but all the other motions are perfect. The eyeball is much congested. The pupils are equal. Dr. Reid reports that on the right side the vitreous is muddy, the nerve pale and atrophied, and the vessels congested. There is no papillitis, and the left nerve is normal. Dr. Barr, who examined the ears, reports that the right-sided deafness is due to chronic catarrh of the middle ear, and not to involvement of the auditory nerve. There is a glandular enlargement between the angle of the jaw and the ear. The tumour, of older date, above the clavicle, is a sebaceous cyst.

No history of syphilis is obtainable, but on examination of the trunk an eruption is found, which consists of spots and blotches like iodic acne, but darker in colour than usual, some of the patches being distinctly coppery. The rash was produced by iodine administered before admission.

Dr. Anderson diagnosed a tumour at the base of the brain on the right side, involving the fifth and sixth nerves, the portio dura of the seventh, and the third partially, and possibly syphilitic, on the following grounds:—

(1.) The history of patient's children (two deaths at three months and one still-birth, all within the last six years).

(2.) The number of cranial nerves involved.

(3.) The nocturnal character of the headache.

(4.) The characters of the iodic eruption.

For the first few days the patient was given the following pill:—

R.—Hydrarg. perchlor., ... gr. ij.
Ext. cinchonæ, ... ℥ i.
H. pil. xxiv. Sig.—Two daily.

Under this treatment there was a distinct improvement in intelligence, and the headache disappeared. The other symptoms remaining unaltered, daily inunction of 1 drachm of mercurial ointment was begun on 30th January. The congestion of the eyeball then diminished rapidly, as did the inflammation of the nose and the discharge therefrom. For some time the glandular swelling also diminished, but on 18th February it increased in size to a considerable extent, and the skin over it became inflamed. Up to 20th February neither paralysis nor anæsthesia had been at all affected by the treatment.

From this date onwards there was no further improvement. The glandular swelling in the neck, enlarged yet more, softened in the centre and was opened, giving vent to a considerable quantity of unhealthy pus. The incision did not heal, and there was a constant purulent discharge.

In March the right eye became the seat of an acute inflammation of the cornea and iris, which resulted in complete loss of sight. The general health, meantime, did not show much alteration, although the patient became somewhat thinner and weaker. He remained in much the same condition until the evening of 5th May, at 9 P.M., when he suddenly became unconscious, passed into a state of profound coma, and died at 10·40.

Post-Mortem.—Head.—The convexity of the brain presents nothing remarkable. In removing the brain, considerable adhesion to the dura is discovered. The adhesions are almost limited to the right side, being as follows:—The optic commissure is adherent in the sella turcica, and the pituitary body seems to be involved in adhesions and new-formed

tissue. The right temporo-sphenoidal lobe is adherent on its internal and inferior surfaces. The pons is adherent on the right side, and there is softening and some hæmorrhage visible on its surface; whilst on section a grey tumour-tissue is visible in the form of a more or less rounded nodule three-eighths of an inch in diameter, extending into the substance of the pons for about a quarter of an inch. The left lobe of the cerebellum is also adherent, and somewhat softened on its under surface. The corresponding portions of the dura are thickened, infiltrated, and adherent to the bone, which is considerably swollen and softened, so that a needle can be pushed into it in various places to a distance of from half-an-inch to three-quarters of an inch.

Liver.—The right lobe presents at its anterior edge, and at the extreme right, a tumour-mass 2 inches in diameter at the surface of the edge, and 1½ inch from without inwards. It is obviously composed of a congeries of coalesced tumours, whose individual diameter may be in general from a quarter of an inch to three-eighths of an inch. The under surface of this region shows a rounded tumour, consisting of somewhat isolated nodules, some of which extend as far as 2 inches outwards from the tumour. None of these exceeds three-eighths of an inch in diameter. In addition, there are visible at the surface, at wide intervals, a few scattered tumours, mostly of small size, whilst on section there are also visible a few tumours. In the portal region of the liver there is a group of enlarged and apparently infiltrated glands.

The other organs present nothing remarkable, save that the pericardium contains 10 oz. of clear yellow fluid.

On cutting deeply into the right side of the neck, where a suppurative condition is visible, two or three glands enlarged and infiltrated with grey tissue are observed. There is slight enlargement of the mesenteric and inguinal glands.

Microscopic examination of the tumour in the base of the skull proved it to be carcinomatous, originating probably in the sphenoidal sinus.

13. *Chorea treated with Exalgin.*

E. M., a girl, aged 15, was admitted to Ward VII for the second time on 20th December, 1892, suffering from chorea.

Her previous admission was due to the same disease, which she then had for the first time. The attack was much more severe than the present one, and was accompanied by some paresis of the left arm. It affected the left side as it does now. She was treated by arsenic, and, after a stay of nearly

three months in the Infirmary (3rd August to 26th October, 1886), was dismissed well.

Her general health has remained good since then, and she was free of choreic symptoms until recently. Four weeks before admission she got a fright, due to a fire, and a week or more afterwards choreic movements began in the left leg and arm. Throughout the attack they have not been very severe. They are worst when she is at rest, and are relieved by work or other occupation. Her bowels are very costive. She menstruated a week before admission, but not for six weeks previous to that.

Both her parents are alive and well, though the mother is delicate. They had seven children, of whom she is the sole survivor. She has no information as to the causes of death of the others.

On examination, the cardiac apex is found to be slightly displaced upwards. There is no murmur. The other organs are healthy, and the temperature and urine are normal.

The patient was treated by exalgin, which she received in increasing doses, as follows:—

Dec. 21,	Exalgin, gr. ii, t.i.d.
„ 28,	Regulate bowels with Carlsbad salts.
Jan. 3,	Exalgin, gr. iv, t.i.d.
„ 9,	„ gr. v, „
„ 12,	„ gr. vi, „
„ 14,	„ gr. viii, „
„ 16,	„ gr. x, „
„ 18,	„ gr. xii, „

At this date the choreic movements had entirely ceased. She complained of headache, with giddiness and faintness. The exalgin was therefore stopped until 25th January, when ten grains were given thrice daily, and from that time the doses were gradually decreased. She was dismissed perfectly well on the 30th January.